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EXPERIMENTS IN MENTAL HOSPITAL ORGANIZATION*

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I WANT to spend five minutes reminding you of the structure of the National Health Service in Britain so that the background to my talk is clear, then five minutes telling you about the major recommendations of the Royal Commission's Report on the Law Relating to Mental Illness and Mental Deficiency. Thereafter I shall try to show you that the general principles underlying the Commission's Report are in accord with the general trend of developments in the mental health services and mental hospitals in recent years; this of course is as it should be if there is to be acceptance of a report.

NATIONAL HEALTH SERVICE

The National Health Service in Britain is administered centrally by the Ministry of Health advised by a Central Health Services Council and various committees. There are three main divisions of the Service:

1. Hospital and Specialist Services.
2. Local Authority Services: After-care, maternity and child welfare, midwifery, health visiting, domestic help in sickness, prevention (e.g. vaccination), ambulances, health centres.
3. Practitioner and Dental Services.

So far as the mental health services are concerned, the central authority includes not only the Ministry but also the Board of Control. Most of the functions of the latter have passed to the Ministry excepting those dealing with the liberty of the subject. The change is an important one and I shall refer to it later.

Turning now to the three main divisions:

Hospital and Specialist Services.—The 14 Regional Hospital Boards, which look after regions with populations varying from one to three million, are responsible for all the mental hospitals (147,000 patients) and all the mental deficiency hospitals (60,000 patients) and for the outpatient services.

Local Health Authorities.—They are responsible for the care of the defectives in the community (80,000) and for the prevention of mental illness and for the after-care of those who have been in mental and mental deficiency hospitals. The medical officers of health are becoming increasingly keen on this work, their Society has recently established a psychiatric section, and there is more psychiatry in the syllabus of the course for the D.P.H.

The way in which the work of M.Os.H. has developed is worth considering for a moment. Starting in 1856, their activities for the first 50 years were directed to sanitation and the prevention of epidemics. This was essential because at that time the population had doubled in 50 years (9,000,000 to 18,000,000) and the Industrial Revolution was in full swing. Unbelievable conditions of filth, squalor and misery existed. In 1830 over 30% of children died before the age of five years. Cholera killed 90,000 people in the four famous epidemics between 1831 and 1866; typhoid and typhus raged. In the second 50 years the drive, so far directed to sanitation and environment, was extended by changing it, as has been said, "from the premises to the person"; and so the M.Os.H. took responsibility for the school medical services, maternity and child welfare, T.B. and V.D. services. Social medicine had started. And now in the third 50 years the public health service is becoming actively concerned with man's human relationships in the home, the school and the society in which he lives and works. The M.Os.H. are realizing that mental hygiene is just as vital as environmental and personal hygiene and that it is quickly becoming one of their main responsibilities. There is good reason to hope that in the next 50 years there will be advances in the promotion of mental health and prevention of mental illness just as great as the advances made in other fields of public health in the past.

Practitioner Services.—The practitioners are much more interested than they used to be. Thanks to better education of medical students you get many fewer letters at the psychiatric clinic saying "Seems queer, please see and treat", and many more which show a real appreciation of the psycho-

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logical aspects of illness. Practitioners have always had to look after the mental health of the patients and families under their care, but now they are applying knowledge to what they handled before by intuition.

THE REPORT OF THE ROYAL COMMISSION ON THE LAW RELATING TO MENTAL ILLNESS AND MENTAL DEFICIENCY

The Commission was appointed in 1954 and presented a unanimous report in May 1957. This has been very well received and the principles are not disputed, though there is much to be discussed about the methods advocated in the report to achieve the desired results. The main recommendations are:

1. To put mentally ill and mentally defective patients as far as possible on the same footing as patients with other forms of illness or disability.

2. To expand the community services including residential services for all groups of mental patients. This involves a great increase in local authority work.

3. To abolish the special designation of hospitals as mental or mental deficiency hospital, thus making any hospital free to accept psychiatric patients on an informal basis even if it is also authorized to accept those who must continue to be subject to compulsory powers. This will give more scope for proper classification.

4. Revision of procedures for admission and discharge and of facilities for review where compulsory powers are used, and the abolition of the present distinction in this respect between mentally ill and defective.

5. Recognition of three main groups of patients (mentally ill, psychopathic and severely subnormal) instead of two (mentally ill and mental defective).

CENTRAL DEPARTMENTS

The process of treating the mentally ill in the same way as the physically ill had been proceeding, so far as central administration is concerned, ever since the functions of the Board of Control, apart from those relating to liberty, were taken over by the Ministry of Health in 1948. It has been a leisurely, unexciting, revolutionary change. In the old days the Board of Control had separate premises and staff and dealt with all aspects of the mental service; its commissioners were expected to be and often were experts in laundries, diets, clothing, farms, etc., as well as being good clinicians and lawyers. The members of the Board remain independent in so far as liberty is concerned, but in all other respects work for the Ministry as specialists in mental health. Now the general work has been passed to the appropriate departments, e.g. outbreaks of infectious diseases are dealt with by the epidemiologists, nursing problems by the nursing division, and so on. It has been fascinating to watch the various officials, medical and lay, gradually stop making their silly little jokes about trick cyclists, hypnotic eyes, etc., and come to accept responsibilities of the mental health service as part of their ordinary duties. I am sure this kind of integration is right, and in this I am supported by as great an authority as Plato, who wrote, "The greatest mistake in the treatment of sickness is that there exist physicians for the body and physicians for the soul and yet the two are one and indivisible". I am sure, too, that the Royal Commission was right to accept the suggestion made by the Board of Control itself that it should commit suicide and be abolished.

OUTPATIENTS

Another way in which the unnatural division between mental and physical illness is being broken down is the acceptance by the general hospitals of psychiatric responsibility. We believe that psychiatric outpatient work should be done in the outpatient departments of general hospitals but that the psychiatrists should come from the mental hospitals, to achieve continuity of treatment and avoid isolation. It is now generally accepted that any all-purpose outpatient department must include facilities for psychiatric O.P. work and that every mental hospital psychiatrist, senior or junior, should spend a considerable amount of time doing community work and not spend all his time in the hospital.

In 1930 there were practically no outpatient departments; now there are nearly 500 for adults, of which less than 100 are at mental hospitals. There are probably enough clinics now and the need is to staff them better and provide better treatment. The unit at St. Thomas's Hospital in London illustrates my meaning. In 1948 there were, in round figures, 600 new patients and 4000 attendances. In 1956 there were 1200 new patients and nearly 14,000 attendances, of which 5000 were for psychotherapy and 9000 for special treatments such as electroconvulsive treatment, methedrine, CO_2 and modified insulin.

ADMISSION WITHOUT LEGAL REQUIREMENTS

Just as psychiatric O.P.D.s are generally accepted, so we are now getting acceptance of the principle that every general hospital should have some psychiatric beds and that *they should be linked with a mental hospital*. There are already between 6000 and 7000 beds for the informal admission of psychiatric patients; these are distributed among special annexes for old people, general hospitals and mental hospitals. The patients are admitted in exactly the same way as ordinary medical or surgical patients. As the law stands at present, mental hospitals designated as such are only

allowed to admit statutory voluntary, temporary and certified patients under the Lunacy and Mental Treatment Acts; and even the voluntary patients, who form over 78% of the admissions, have to sign forms and be reported to the Board of Control. The patients to whom I am now referring are completely outside the scope of the Acts. To achieve this it has been necessary to redesignate parts of mental hospitals so that legally they are no longer regarded as such. Thus another of the Royal Commission's recommendations, namely, that mental patients should wherever possible be admitted in the same way as ordinary patients, is already under way. All the teaching hospitals now have their own inpatient as well as their own outpatient departments, with perhaps two exceptions, one being my own hospital, St. Bartholomew's, which, with a tradition of nearly 850 years behind it, does not believe in accepting new-fangled ideas such as women doctors and psychiatry too rapidly, despite the fact that it received its Royal Warrant from Henry VIII at the same time as Bethlem did.

SIZE OF MENTAL HOSPITALS

You will remember that I stressed that any unit in a general hospital should be linked with a mental hospital. This I believe to be vital; we don't want the kind of mental hospital psychiatrists who work alone in big isolated mental hospitals. As a matter of fact, we don't want big mental hospitals, though we've got them and have got to put up with them, but don't let us build any more. The early mental hospitals in England were not big and were not isolated (e.g. Bethlem, and St. Luke's in London, Bootham Park at York, Cheadle Royal in Cheshire). Hanwell, built in 1831 with 800 beds, was rightly regarded as a monster, and Connolly, its famous medical superintendent, doubted whether he could carry out his policy of humane treatment in it. Dr. Kirkbride, one of the 13 founder-members of the A.P.A., insisted that 200-300 was big enough for a hospital. The 5th Report of the W.H.O. Expert Committee on Mental Health says "the good hospital will be comparatively small"; a recent study for W.H.O. by two psychiatrists and an architect, as yet unpublished, recommends a limit of about 300 patients, with ward units of not more than 30 patients suitably subdivided. Again, this is not new. In 1819 Samuel Tuke ("Practical hints" from a document printed in 1819 concerning the building of Wakefield Asylum) wrote, "In regard to the number of patients who may be allowed to occupy one room, I incline to think that the number ought in no case to exceed fifteen." Again, "I incline to think that the probability of recovery is greater where a moderate number of persons associate together", or again, "When all the evils of large associations are considered it is not perhaps too much to attribute to it in degree the small proportion of cures in some of our larger establishments."

If there is a request for a new 1000 bedded hospital I would urge that there should be two schemes each the equivalent of 500 beds. Then I would distribute the beds like this:

Good O.P., day hospital, and home visiting facilities, means 100 beds not needed. Accommodation, provided either by the Hospital Service or in the community, for old people who though mentally enfeebled do not need or no longer need the facilities of a mental hospital, 100 beds. Short-stay accommodation in general hospitals, 50 beds. Beds for rehabilitation of longer-stay patients, 250 beds. But no one is very sure how many of the long-stay beds are necessary, so let us start with a hundred and add to them as required.

In case you think I am living in fairyland, let me tell you what has been happening. Firstly, in the Manchester Region. There, owing to circumstances which I need not detail, there are some psychiatric units of 100 to 200 beds attached to general hospitals. Each has its own catchment area, from which it admits all types of mental illness, and provides appropriate treatment; each is linked with a big mental hospital to which it was anticipated they would send a stream of patients. To our surprise they are sending only a very small number and seem to be able to deal with their case load without getting silted up. We are inclined to think that this is because the units are small, so patients get individual attention, they are in the centre of the community so they don't lose touch with their friends, there are no vast grounds so they go into the town for their recreation and attend the local cinemas and football matches instead of special hospital ones. It would appear, in fact, that one of the most important trends in psychiatry is a change from a demand for more beds in big isolated hospitals to a demand for more adequate treatment in more suitable surroundings; it is improbable that any further mental hospital beds of the traditional mental hospital type will ever be required, and to me it is certain that the provision of more and more beds is not the way to overcome overcrowding.

TREATMENT IN THE COMMUNITY

Now let me tell you about another interesting experiment being carried out at Graylingwell Hospital in the South of England. For years we have been praising hospitals for increasing their turnover; admissions have jumped from 55,856 in 1950 to 88,542 in 1956, length of stay has shortened, 78.5% of the admissions are voluntary, more in the good hospitals. Recently we have come to think that it is time to encourage hospitals to cut down their admission rate so long as they are able, as we think they should be, to provide adequate treatment in the community. At Graylingwell the admission rate was 735 in 1950, while for 1956 it was 1347, an increase of 82.3%. The increase of the admission rate looked as though it

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would continue indefinitely, and it was decided to try an experiment to see if expanded facilities for outpatient, day hospital and domiciliary treatment could materially affect the great annual increase of admissions to the mental hospital. The experiment was backed by the Nuffield Provincial Hospitals Trust and is going on now. The area served by this pilot experiment is one with a population of 160,000 people. The effect of the experiment is checked by comparison with what happened in this area in 1956, and by comparison with another area of the same size which also admits patients to Graylingwell.

The headquarters of the experiment provide accommodation for an outpatient department, a day hospital and a domiciliary service.

The results have been startling.

Admissions to Graylingwell Hospital	*1956*	*1957*
Admissions from catchment area not served by the new service	651	679
Admissions from catchment area served by the new service . . .	601	257

i.e.—A reduction of the admissions by 57.2%.

A point of considerable interest is that not only was the impact of the service felt on the recent, short-stay type of recoverable patient, but also on the admission of the more advanced and acutely mentally ill patient upon whom much effect was not expected. Among these there has been a 40% reduction.

The effect of this service on the admissions of old patients, i.e. patients over 65, is also important when it is remembered that national statistics show that 20% of those admitted and 30% of mental hospital residents are over that age. Here the effect is most apparent in the 65-75 age group, but among the whole group of 65 years and over there was a reduction from 186 to 107, i.e. 42.5% reduction.

GERIATRICS

In the Oxford Region, Dr. Cosin at the Cowley Road Geriatric Hospital has been an active developer of new ideas about geriatrics. So far as the effect of his work on the mental hospitals is concerned, the Senior Administration Officer writes in his annual report, "The link now formed with acute geriatric units has been of great advantage. The proportion of patients admitted over the age of 65 to mental hospitals in this region was until recently as high as 25% of all admissions. It has been shown that this can be reduced to 10% or even lower by admitting patients to a geriatric unit and sending to a mental hospital under certificate only those with violent or difficult behaviour." This is not another service being removed from the mental hospital; it is a joint enterprise with the psychiatrist from the mental hospital attending the geriatric unit regularly.

Everything must be done to avoid the common idea that once an old person goes to hospital all hope has gone and the relations are absolved of responsibility. A follow-up of patients in three hospitals showed 40% discharged after two years, most of them in the first year.

At Mapperley Hospital in Nottingham elderly patients are always seen before admission and then, if there is any expectation of prolonged mental hospital care not being needed, the relatives are given a fixed date, usually about a month or six weeks ahead, on which to take the patient home. The patient hears this being done, so neither patient nor relative gives up hope.

The medical superintendent of Mapperley Mental Hospital has achieved such excellent cooperation between the local authority and regional hospital board services that it can be said with truth that a state of complete integration into a single mental health service has been achieved. This integrated service has been described by Dr. D. MacMillan (*Lancet*, 2: 1094, 1956).

DAY HOSPITALS

I am not going to talk about day hospitals; after all, one of the first was started here in Canada. Unfortunately, the term "day hospital" is as uninformative as terms like "psychopath" or "group treatment". If they are to make sense they must be defined when they are used. There are now about 20 day hospitals in England, and no attempt has been made to create a uniform type.

STAFF

All these activities, additional but related to inpatient services, need more staff and the staff must be well trained if they are to be effective. In England there has been an increase of more than 50% in the number of psychiatric consultants in the National Health Service since 1949 and more are needed. It is essential that there should be a good supply of well-trained psychiatrists to follow on. It is the duty of the departments of psychiatry in the universities and the psychiatric teaching organizations to see to this, and they need constant support in their efforts to develop an interest and enthusiasm for psychiatry in both undergraduates and graduates. This means that good teaching and research work on inpatients and outpatients must be carried on in the same way as they are in other branches of medicine and must be just as available to students.

INPATIENTS

Now it is time to say something about the patients who go into hospitals. They fall into two groups, the short-stay and the long-stay. I don't want to say much about the short-stay cases, by which I mean a stay of under a year. I choose a year because over 90% of all patients who are

discharged are discharged within a year. I think too many are being admitted, but the increased demand is striking and indicates that there is a real need for beds for short-stay patients, and that there is a marked loss of fear of mental hospitals and a growing appreciation of the treatment that they can give. In 1946 there were approximately 36,000 admissions, of which 18,000 (50%) were voluntary. In 1956 there were 88,542 admissions, of which 69,479 (78.5%) were voluntary. More than 55% of those admitted were discharged within three months and over 70% within six months. A combination of spontaneous recovery and good results from early treatment ensures interest and a sense of encouragement regarding these patients.

What about the long-stay cases? Although the percentage of admissions left after death and discharge at the end of a year is comparatively small, it accumulates and occupies more than 80% of the accommodation. What is being done about them? It is interesting that something seems to be happening, because in Canada and New York, as in my country, the number of those in residence is beginning to fall.

PERSONS UNDER CARE IN ENGLAND AND WALES

Year	*No. of patients*	*Increase or decrease*	
1949	147,288		
1952	149,353	plus 2065	
1953	151,378	" 2025	
1954	152,144	" 766	
1955	150,856	minus 1288	(Redesignation = 649)
1956	149,480	" 1376	(Redesignation = 308)

I believe that the reduction follows an increasing appreciation that many of the long-stay patients have become chronic, not because of their illness but because of the kind of hospital regimen in which they have been forced to live. This need not be unkind; a kindly taking-over of all responsibility from the patient can be just as destructive to his personality as cruelty or neglect. It has become clear that the group of chronic patients is not the static mass of unmodifiable and antisocial humanity it was thought to be. In England the physical methods of treatment such as E.C.T., insulin and leukotomy, and the tranquillizing drugs (which can be such a menace outside the hospital and such a blessing in it) have made many patients more accessible and more able to react to methods of rehabilitation, and so there is a steadily growing interest in the effect of the therapeutic community, group treatment, the open hospital, industrial schemes, etc., on the chronic population of mental hospitals.

THERAPEUTIC COMMUNITY

Let me say something in the first place about the so-called "therapeutic community", and start by quoting Rapaport (*Human Relations*, Vol. 9, No. 9):

"This term has come into vogue among those who seek to create a social milieu which is in itself therapeutic and which can also be beneficial as an integral part of other forms of treatment. Research by sociologists and psychiatrists in this field has brought to light factors that hinder effective utilization of the social environment for therapy; such factors are the wasted energies of informal ward interaction, the social barriers between patients and staff in the treatment situation, disturbing effects of hidden staff disagreements, personal barriers to liberalizing hospital staff attitudes."

A therapeutic community which has had a big influence on current mental hospital organization in England is that of Dr. Maxwell Jones at Belmont. This was originally set up in 1947 to study what could be done for neurotics with special difficulties with regard to employment. It soon became apparent that most of the patients had personality problems and corresponded closely to what is usually meant by psychopaths; frequently they had histories of long periods of unemployment and antisocial behaviour, with, perhaps, criminal records. Both psychiatrists and Labour Exchange officials have in the past felt hopeless about this problem group. Strict attention to the social milieu within the hospital, special group techniques, co-operation with the Ministry of Labour Training Centre nearby and testing in real-life situations in various employments provided by over 30 co-operative local employers have led to surprisingly good results. A follow-up of about 100 patients 6-9 months after discharge showed that 53% had worked full time since leaving, and 67% had made a fair adjustment. In treating these personality problems the importance of the family had become more and more apparent, and family group meetings are now held in the unit to bring other members of the family into the treatment situation. I have no time to talk about the methods used, but the work of a research team on the therapeutic community at Belmont over the last three years will soon be published and a long-term follow-up is being carried out.

Many big mental hospitals have been studying how to make their hospitals more effective as therapeutic communities. Netherne Hospital has, perhaps, given more thoughtful study to it than most, with the result that a variety of changes have been made and a variety of experiments tried. One of the first principles has been acceptance of the need to have the enthusiastic co-operation of the staff, and a lot of thought has been given to the problem of communication between different strata of staff, so that all might understand the purpose of any change.

One experiment has been the splitting of a large ward of 150 of the most deteriorated patients into three groups, each of which was moved into a smaller ward so that the population of each of the three was fifty. The staff of each consisted

of a head nurse, two nurses and a ward orderly. After a difficult initial period of rejection and hostility the experiment got under way. I cannot here describe the routine of habit-training that was developed, but within three months it was found possible to train a group of 50 to quite a different standard of living. At first 33 patients were incontinent, now only one is. Of the original 50, only 4 were at all occupiable, now 17 do regular ward work, 17 attend occupational therapy and only 16 are not usefully occupied. They look healthier and less slovenly; they have put on an average of 14 lb. in weight. Their table manners are markedly better, they do not quarrel and they are much calmer.

Dr. Monro at Long Grove Hospital when he starts a change always puts into the unit where it is to be tried patients from wards all over the hospital, so that when they go back they will talk about it to staff and other patients. He reckons that it takes about four years of careful propaganda in a hospital before major changes can be attempted.

More recently another experiment has been tried at Netherne. It was observed that social instincts, however dormant, became observable at social events when the sexes were mixed. Women who were aggressive and obscene before a social event in a male ward became co-operative with the nurses when the actual event took place. On return to a ward after a social gathering there was nearly always a relaxed atmosphere and they all settled down quickly and went quietly to bed. It seemed possible that if given opportunity to meet and mix with the opposite sex the men and women should, if their behaviour at socials was any indication, benefit in many ways, and so the experiment was started.

Two villas side by side were used each for 43 of the most deteriorated patients in the hospital. Apart from sleeping arrangements, the sexes mix freely for work, meals and recreation. After six months the following noticeable changes for the better have been noted:

1. Increased sense of responsibility.
2. Greater attention to toilet and appearance.
3. More male patients shaving themselves, shorter time needed for dressing.
4. Increased spontaneity, e.g. asking for help when feeling depressed.

The staff had more difficulty in adjusting to the change than the patients and a weekly ward meeting was essential as a safety valve. At this meeting the staff express complaints, pool resources, reassure each other and bolster each other's morale.

INDUSTRIAL WORK FOR REHABILITATING CHRONIC PATIENTS

The importance of regular useful work in preventing deterioration has long been known and so has the converse, viz. that an inactive regimen can aggravate, if it does not actually cause, the condition of the patient. In 1801 Pinel wrote: "It is noteworthy that silence and tranquillity prevailed in the Asylum of Bicètre when nearly all the patients were supplied by the tradesmen of Paris with employments which fixed their attention and allured them to exertion by the prospect of a trifling gain." Despite the recognition of this, there has been a tendency for occupational therapy to become divorced from real work. Between 1949 and 1954 members of the M.R.C. Social Psychiatry Research Unit showed that both high-grade and low-grade mental defectives could be trained to perform simple industrial tasks and that if these patients were employed on practical work, for which they could earn money, their social recovery was accelerated. This work was carried out at the Manor Hospital, near London. The unit then transferred its activities to Banstead Mental Hospital, where they have shown that patients, long considered to be unemployable, can carry out simple industrial work and earn money. It is of interest that the best incentives are money and social prestige and that the most difficult group of patients are the chronic schizophrenics, especially the paranoid group, who showed themselves relatively impervious to both financial and social incentives. Dr. Carstairs, director of the unit, compares them to shy children who refuse the advances of over-demonstrative adults but soon regain confidence if not made the centre of attention. He considers that it is not the reward which these patients reject so much as the disturbing experience of an unfamiliar person engaging them in an interpersonal relationship.

Industrial schemes employing long-stay patients on remunerative work have started in about a dozen other mental hospitals, notably Cheadle Royal and Fulbourn; the greatest difficulty is the provision of suitable industrial work, even in a time of full employment.

A further development of the principle of enabling suitable patients to work in factory-like conditions has been achieved with the help of the Ministry of Labour and National Service, who have made it possible for suitable patients to work in their Industrial Rehabilitation Units. The I.R.U.s are intended to bridge the gap between the hospital and the factory, and they have taken work therapy further than has been attempted before on a large scale. They are available to people handicapped either physically or mentally. The moment a patient enters an I.R.U. he leaves the protective atmosphere of a hospital and feels himself back in a working environment; to quote from an article describing this:

"It is the sense of purpose behind the tasks in the workshops, and the fact that working hours are spent in an authentic industrial atmosphere (complete with clock-punching) that do most to restore the ex-patient's confidence in himself. When he has successfully faced

industrial conditions in the I.R.U. he knows that he can face industrial conditions outside; and the physical as well as the mental condition of many patients improves rapidly the moment this truth dawns on them."

Up to the end of 1955 over 200 patients from 29 mental and mental deficiency hospitals had attended; 81 were neurotic, 75 psychotic and 52 mentally deficient. The results of the scheme indicate that mental and mentally deficient patients have almost as good prospects of satisfactory resettlement as have the other patients who attend the I.R.U.s mostly for medical and surgical conditions.

FREEDOM

As a natural corollary to the methods of treatment and rehabilitation to which I have been referring, it has become possible to give to patients much more freedom than could have been thought of some years ago. A survey of the 106 big mental hospitals which contain 95% of the statutory patients in England and Wales showed that they contained a total of 2684 separate ward units (i.e. day and night space) and that two-thirds (1785) were unlocked by day and only one-third (899) locked. Twenty-three hospitals have less than four locked ward units, including eight hospitals with none. These eight are not all in one part of England but are scattered all round it. I myself am as yet not sure whether it is wise to try to open every ward, but I am sure that it is good to open all except one, or possibly two, on each side of the hospital. One vital principle of the open hospital is that the staff must support and approve of all changes made; they must be continually stimulated and supported, for if doors are to be opened the mental hospital must be a happy and confident place. Patients must be happily occupied and their occupations should be outside the wards, which should be used mainly for eating and sleeping. Recreations too must be provided away from the wards. The patient must be respected as a person. His complaints and requests and those of his relatives must be given due consideration. Clothing must be good. Holidays and visiting must be encouraged. Even the hostility of the paranoid patient can be worn down by constant kindness. Why should a patient leave the only place where he can always be sure of a kind word and a sympathetic ear?

I would like to quote from two articles about open hospitals. Firstly, from an article by the chief male nurse of De la Pole Hospital, near Hull: he writes:

> "I have attempted to describe how we cleared the airing courts and exercise grounds and instituted group therapy for rehabilitation of chronic patients. One by one we removed the freedom-thwarting, morale-depressing spring locks from every ward door. With the absence of these clanging, self-retaining door catches, a new atmosphere pervaded these hitherto constantly locked wards. Everything and everyone within them appears to have brightened up. A strange, relaxed peacefulness has taken over from the harsh, militant, prison-like surroundings which dominated the old asylum routine."

Secondly, from an article by Dr. Bell, who was a pioneer of the open hospital in Scotland. In it he mentions the effect of the open hospital on visitors. He quotes from the nurses' notes:

> "After four years of the open door system we, the members of the nursing staff, note a great change in the attitude of patients' relatives. They now appear to regard us as the patients' friends, whereas in the old days most visitors regarded us with considerable disrespect. We think the reason was that the nursing staff had to escort them along the corridors, locking every door behind them. In those days we were more or less looked on as jailers. The new approach is very welcome to us."

Perhaps at last we are reaching the day when we can remember without an uneasy pricking of conscience Florence Nightingale's statement that "The first requirement of a hospital is to do the sick no harm", or more recently, the late Dr. Kraus's view expressed in a W.H.O. memorandum that "bad mental hospitals are worse than no mental hospitals".

TRENDS

What then is going on in British psychiatry?

1. Mentally ill and mentally defective patients are as far as possible being put on the same footing as patients with other forms of illness or disability. The increasing outpatient and inpatient facilities at general hospitals are evidence of this; so too is the increase in the number of voluntary patients admitted to mental hospitals and the development of units at them to which patients can be admitted informally in exactly the same way as to general hospitals.

2. The realization that mental hygiene and early treatment in the community can promote good health, prevent or arrest illness and in many instances avoid the need for admission to hospital.

3. The realization that the community can care for many mentally ill and defective patients who are at present isolated in special hospitals and institutions. These patients can, with proper incentives and rehabilitation, support or partly support themselves, instead of being a constant drain on national resources, with benefit both to the individual and to the community.

4. The realization that big hospitals are apt to be bad hospitals and can be potent factors in the creation of chronic patients.

5. The realization of the importance of a therapeutic community and of active rehabilitation

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methods, and that the way in which these can be developed can be studied scientifically by suitably trained persons.

6. In the field of mental deficiency the extension of vocational training methods, better supervision of defectives in the community, extension of day-hospital facilities and more intensive habit training will result in more defectives being cared for in the community and an increased proportion of low-grade patients in the hospitals.

Finally, I would like to express a strongly felt belief that central dictation, however tempting and however sound, must be kept down to a minimum in order to ensure that a sense of responsibility for progress is preserved among those who do the actual work.

Experiments in all fields of psychiatry must continue and can continue with safety so long as those concerned remember and agree with the wisdom of Seneca, when he wrote *Res sacra miser*—"A sick person is sacred."

RÉSUMÉ

Les tendances actuelles qui se dégagent de l'état de transition par lequel passe la psychiatrie anglaise sous le Service de la santé nationale peuvent se résumer comme suit:

Les malades mentaux et les arriérés sont autant que possible considérés sur le même pied que les malades souffrant d'autres forms d'affection ou d'infirmité. L'amplification des facilités des dispensaires et des salles d'hôpitaux généraux en témoigent, de même, l'augmentation du nombre des patients volontairement admis dans les hôpitaux psychiatriques, ainsi que le développement dans ces institutions d'unités où l'on peut admettre des malades sans plus de formalités que dans les hôpitaux généraux.

Les autorités se rendent compte que les mesures d'hygiène mentale ainsi que l'application d'un traitement précoce au sein de la communauté conservent la santé, préviennent les maladies ou les enraient dès leur début, et dans plusieurs cas, évitent le besoin d'hospitaliser le malade. Elles se sont aussi rendu compte que la communauté peut se charger de plusieurs malades mentaux et arriérés qui sont actuellement casés dans des institutions et des hôpitaux spécialisés. Ces malades avec de l'encouragement et de la réadaptation peuvent subvenir à leur propres besoins, entièrement ou en partie, au lieu d'être à charge à la société de sorte que l'individu lui-même et la communauté y gagnent de part et d'autre.

On a enfin compris que les très grands hôpitaux risquent de n'être pas de très bons hôpitaux; qu'ils contribuent beaucoup à rendre chroniques les malades qui y stagnent. On reconnaît l'importance du milieu thérapeutique que peut offrir l'hôpital et des méthodes de réhabilitation active dont l'évolution est à même d'être étudiée par des personnes préparées à cet effet. Dans l'arriération mentale, une meilleure orientation selon les aptitudes, une plus grande surveillance des simples d'esprit dans la communauté, un emploi plus complet des services qu'offre l'hôpital pendant la journée, ainsi qu'une formation plus poussée des habitudes, permettront à de nombreux arriérés de subsister dans la communauté et augmenteront la proportion des petits mentaux dans les hôpitaux.

On doit résister aux tentations qu'offre la centralisation dans ce domaine afin de ne pas dépouiller ceux qui, en fait, accomplissent le travail, de leur sens des responsabilités.

A FOLLOW-UP STUDY AFTER THOROTRAST CAROTID ARTERIOGRAPHY*

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THOROTRAST, a 24% colloidal suspension of thorium dioxide, was first used as a contrast medium for cerebral arteriography by Egas Moniz in 1931. It soon became extensively employed as a contrast medium for demonstration of the liver and spleen as well as the blood vessels. Thorotrast produces excellent contrast because of the high atomic weight (232) and high atomic number (90) of the thorium in it. There seem to have been fewer allergic reactions with it than with organic iodine preparations. Over 200 articles have appeared on it and a controversy has arisen with regard to its toxic effects. Much of the criticism is due to the fact that several independent workers have demonstrated a carcinogenic effect in animals. Thorium is radioactive.[13-15, 19] It has an extremely long half-life of 1.65 x 10^{10} years and it is poorly excreted by the body. Should it be deposited outside the blood vessels, it produces granulomatous sclerotic reactions at the site of injection. It has been used less in recent years for these reasons.[3, 4, 6, 16, 18, 21, 22]

Because of the extremely long half-life of thorium and also because only about 10% is excreted by the body after intravascular injection, thorotrast is useful for the study of long-term effects of small quantities of internally deposited radioactive material. Such study will lead to better appreciation of the late effects of radioactive elements in the body. Many of the problems are complex, controversial and incompletely understood, and large series are essential for more adequate evaluation of the problems. As yet little information is available concerning the late effects of thorotrast in man.

The effects of thorotrast in man depend on three of its properties, radioactivity, particles of thorium dioxide and the chemicals used for suspending and stabilizing the colloidal particles of thorium dioxide.

When thorotrast is injected into the blood stream, some 90% of the thorium dioxide is rapidly taken up by the reticulo-endothelial cells of the spleen, liver, bone marrow and certain lymphatic glands. The other 10% is excreted through the kidneys during the first 48 hours.[8, 9] The 90% that is taken up is retained almost indefinitely in the body. A point

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